SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

☐ID ☐RD ☐AUTISM ☐TBI ☐SCI ☐SD ☐OTHER

≈≈≈≈≈≈≈≈≈≈≈≈REQUEST FORM - INDIVIDUAL AND FAMILY SUPPORT/RESPITE≈≈≈≈≈≈≈≈≈≈≈≈

Consumer: _____

TCM Provider: _____

Referring Provider Staff Name: _____ Phone: ( ) _____

DSN/Home Board (*if different from TCM Provider*): _____

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Name: _____ Age/Birth Date: _____

Address: _____ Phone: ( ) _____

_____ Medicaid #: _____

Number residing in household: _____ Social Security #: _____

Members of Household - Relationship/Age

_____ _____

_____ _____

_____ _____

_____ _____

Check all that apply:

☐ Medicaid Eligible

☐ Medicaid Eligibility Pending

☐ DHHS Waiver

☐ Waiver Participation at hone

☐ Waiver Enrollment Pending

☐ Waiver Waiting List - Critical

☐ Waiver Waiting List - Non-Critical

Is the consumer currently employed? ☐Full-time ☐Part-time ☐No

REQUEST INFORMATION

Type Requested	Amount Needed	Timeframe for Needed Assistance
☐ One-Time	$_____	_____
☐ Ongoing*	$_____	_____

*Provide detailed information
About costs of items requested

JUSTIFICATION

Explain the purpose/objective - how it will be used and for what service/need and how it ties back to either of the two priorities listed in Directive 734-01-DD.

MONTHLY HOUSEHOLD INCOME

This page applies only to IFS (and not for requests for Respite Services)
If additional space is necessary, attach a worksheet to this form

Income Sources	**Amount**

Total Monthly Income $_____
(attach copy of income verification)

Describe how consumer's SS Income or other non-earned income is used:

I certify that the above consumer information is true and complete. I understand that submitting false information or use of Individual and Family Support Funds or respite for purposes other than as requested may result in termination of assistance and a payback of expended funds to DDSN.

Consumer or Parent or Legal Guardian _____ Date _____

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Received Date: _____ Review Date: _____

Amount: $_____ Approved Period: _____

☐Approved ☐Denied (see reason below) ☐No Action, returned to referring staff (see below)

Comments: _____

_____

_____

_____

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_____

_____

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_____ _____

DSN/Home Board Provider Administrator Date